

KELSEY (C.B.)

Five Years' Work in Diseases
of the Rectum
At the New York Post-Graduate Hospital.

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FIVE YEARS' WORK
IN DISEASES OF THE RECTUM
AT THE NEW YORK POST-GRADUATE HOSPITAL.
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THE total number of cases treated has been seven hundred and ninety-six. These are divided as follows: Hæmorrhoids, 267; fistula, 107; non-malignant ulceration and stricture, 84; fissure, 55; cancer, 49; pruritus, 42; prolapse, 35; abscess, 34; polypus, 20; malformations, 6; pelvic abscess, 8; fæcal incontinence, 7. The remainder includes all the various forms of disease which find their way to such a clinic, from uterine disease to chronic constipation.

The operations before the class have been as follows: Hæmorrhoids, 137; fistula, 63; fissure, 33; abscess, 23; colotomy, 40; extirpation, 24; ulcers, 25; prolapse, 25; polypus, 15; pruritus, 9; proctotomy for stricture, 8; fæcal incontinence, 5; proctoceles and cervix uteri, 5; intussusception, 1; pelvic abscess, 3; congenital malformations, 3; recto-vaginal fistula, 1; total, 418.

Leaving all of the minor cases with the simple statement that all hæmorrhoids are still operated upon by the

clamp and cautery method because we have yet to find any other plan we like as well, and that we are still waiting to see any of the bad results which Allingham asserts are inseparable from this method, or any of the failures to cure which Whitehead says can not possibly be avoided, we pass at once to the consideration of the cases of stricture and incurable ulceration, for the study of which the clinic has thus far offered such exceptional advantages.

Of these we have shown and examined ninety-nine. Forty-nine have been malignant and fifty non-malignant. Sixty-four have been in males and thirty-five in females. In the last year's report attention was called to the fact that our experience here did not support the usually accepted statement that this disease was nearly twice as common in females as in males; and this fact becomes still more noticeable as the number of cases increases.

As to the nature of the non-malignant cases, four were of dysenteric origin. In them, as a rule, the amount of ulceration is far in excess of the amount of contraction. There is distinct stricture, it is true, but the symptoms of that condition are not as prominent as the discharge of pus and bloody mucus, the tenesmus and wasting away which characterize the ulceration.

Six were congenital and six were due to pressure from without or obliteration of the gut from diseases not primarily of the gut itself. One was distinctly tubercular in character. This leaves thirty-three out of fifty to be accounted for, and all of these are of the kind generally included under the head of syphilitic, although in only six of them was there any syphilitic history, and in only a single case am I convinced that syphilis had anything to do with the pathology. That particular case was a child suffering from well-marked *estheomène* or lupus. For a time she improved greatly under specific treatment, though a few weeks

ago her physician told me the improvement had ceased and the disease had taken on the usual incurable character.

Instead of attributing the thirty-two other cases to syphilis and to some pathological process of which we know nothing connected with that disease, I prefer to consider them the result of a simple proctitis, proliferating and contracting in its results, which may be set up by any local injury to the part, and which, once having passed the early stages, is practically incurable. Anything which causes an abrasion of the mucous membrane may cause a stricture of this variety if the abrasion goes on to ulceration and the ulceration is not cured by proper local treatment.

Again and again we have this history forced upon our attention, and it will in time be allowed its proper weight with all those who are not so overawed by the mass of authority in favor of the syphilitic idea that evidence to the contrary has no influence upon them. Constipation and faecal impaction, surgical operations, injury to the rectum in childbirth are some of the everyday causes of the so-called syphilitic stricture, both in those who have had and those who have not had syphilis. Every practitioner has seen these simple lesions cause stricture of the rectum a few years later if he has watched the development of his cases. How many men have ever seen syphilis cause stricture? I do not mean how many have seen well-developed strictures and have jumped to the conclusion that they were syphilitic. Where in the body do we find any analogous syphilitic process? Neither in the air-passages nor the œsophagus, for here when we find syphilitic stricture we find contraction from cicatrices resulting from syphilitic ulceration. The deposit which causes stricture in the rectum is not gummatous either under the microscope or in its clinical history, and the name ano-rectal syphiloma,

which has covered it as an all sufficient explanation for years, has come to express nothing.

The writer does not wish to be misunderstood in this matter.

Syphilis may cause a stricture of the rectum by causing an ulceration of the mucous membrane exactly as a surgical injury or a scybalous mass may do, and in no other way. I have seen such syphilitic ulceration, and had it not promptly yielded to local and specific treatment I have no doubt that it would have caused a stricture exactly as it would have done in the œsophagus.

That syphilis has any connection or relation with stricture of the rectum except in this way we have no particle of proof. That the so-called syphilitic stricture, both in syphilitic and non-syphilitic patients, may be caused by any local injury we have daily evidence.

Of these ninety-nine strictures, forty have been treated by colotomy, twenty-four by extirpation, and eight by division.

Of the forty colotomies three have died. This statement left without explanation would give a very exaggerated idea of the mortality of the operation. Only one of the deaths was in any way due to the operation, and that one was a pure accident, and might easily have been avoided—indeed, should have been.

The first death was caused as follows: The patient, a woman, was in the midst of complete intestinal obstruction from cancerous disease. The pelvis and abdomen were full of cancerous masses, and after the incision was made it was with some difficulty that a healthy piece of sigmoid flexure and mesentery could be found in which to make the opening. After thirty-six hours the patient had a chill and high temperature and the symptoms of shock. The gut was opened, the parts found in good condition, but the

opening of the bowel gave no relief, nor did any quantity of gas or fæces escape, which, considering the distended state of the abdomen, was considered remarkable. Death followed in a few hours, and upon autopsy the obstruction was found to be unrelieved. A cancerous nodule existed at the splenic flexure of the colon, which had almost completely closed the caliber. Against this there was pressing a small, hard fæcal mass acting as a perfect ball-valve, which had caused death.

The second death was in no way due to the operation. The case was one of acute phlegmonous periproctitis following the division of a stricture. After the patient was exhausted by the disease and at the point of death a communication formed between the rectum and bladder. To do away with this additional cause of danger a colotomy was performed, but without retarding the inevitable result of the disease.

We then had a run of twenty-four successive cases without accident, and the next and last death was directly due to the operation.

The patient, as usual suffering from cancer, was in excellent condition and a favorable prognosis was given. On the second night after the operation the bandages were found soaked in serum, which had wet them through and was soaking into the bed. All night the patient was allowed to remain in this condition before the wound was examined, and I was sent for. Then it was found that many feet of small gut had escaped through the incision and were lying under the dressings. The gut was partially strangulated, deeply congested, all of the coils were matted together by plastic exudation, and the dressing of gauze was so firmly adherent to the protruding mass that an hour's careful dissection was necessary for its removal. By the time the parts had been replaced the patient was in a con-

dition of fatal shock. This is the only case of colotomy, either in private or hospital practice, in which I consider that death could fairly be attributed to the operation. In private practice in two or three cases death has not been delayed by the operation, but in none has it been hastened.

I report this case fully as a warning. The same accident has happened before and may again, but it should never be a fatal one, and would not be if discovered early and properly managed. Sudden and profuse discharge of a large amount of serum from the abdomen after colotomy is a sign that some part of the wound has given way, and should lead to immediate removal of the dressings for inspection. If hernia be found, it is an easy matter to reduce it, and a stitch or two in the wound will keep it reduced.

From the twenty-four operations for extirpation of the rectum there have been seven deaths.

The more experience we have with this operation the more convinced are we that the rate of mortality depends chiefly upon the technique. Of course, the cases for operation must be carefully chosen. In non-malignant stricture the extent of the disease is seldom or never such as to contraindicate extirpation. In cancer the disease must be movable. In other words, no matter what its distance from the anus and no matter what length of gut is involved, the disease must be confined to the gut, and must not have invaded adjacent parts, otherwise attempt at removal is unjustifiable.

The comparison of these statistics with those of other operators is difficult because of the absence of details in the published reports. My own cases are simply twenty-four consecutive ones, in all of which it seemed possible before commencing to completely remove the disease, and the mortality is about that of the German clinics. Had the

severe cases been subjected to colotomy and the mild ones extirpated the mortality would have been less and the recurrences also less. It would be possible to do the operation twenty-four times without any mortality and with few or no recurrences within the limit of five years, but the cases would need to be carefully selected ones of epithelioma confined to a small portion of the gut and removed early.

My own experience has taught me rather to expect recovery without serious accident in a clean and antiseptic Kraske's operation when the upper end of the gut is well vitalized at the point of section and is brought out behind and stitched to the skin at the part left vacant by the removal of the end of the sacrum. Union soon takes place; fæces escape on the surface of the body and do not contaminate the wound, which may be expected to heal in part by primary union; and the patient makes a rapid recovery without high temperature.

This operation is, however, not the ideal one. The disease is removed, it is true, and the great object of operating is thus accomplished; but the after condition of the patient is not as good as after a colotomy.

It may be safely asserted that if a patient is to have an artificial anus anywhere, the best place for it is in the left inguinal region and not over the sacrum.

One great element in the mortality at this clinic has been the repeated attempts not only to remove the disease, but to put the parts in the same condition as before the operation, by uniting the divided ends of the gut and replacing the trap door formed by cutting across the sacrum. When we fail in the attempt to get immediate union of the ends of the gut the wound becomes fouled with fæces, there is suppuration, great exhaustion, and prolonged high temperature, and the patient barely escapes with life.

Attempt at immediate union of the ends of the gut should never be made unless the upper end be well vitalized and well supplied with mesentery. Where the disease has involved the upper rectum, and where after opening the peritonæum it has been necessary to dissect off and divide the mesorectum to a considerable extent to bring the gut down, it will often be found that when the gut is finally cut across above the disease all precautions against bleeding from the proximal end are unnecessary. The circulation has been so interfered with by ligatures placed upon the mesentery that the cut surface has not sufficient blood supply to bleed. Or, in non-malignant stricture, when the same section is made above the constriction the proximal end will be found infiltrated, lardaceous, grayish in color, and with few vessels. It is not to be expected in such cases that good union will take place between this end and the anal portion, no matter what particular form of apposition is effected, and the proximal end under these circumstances should simply be turned out behind and sutured to the skin, care being taken if possible to cut off enough so that healthy gut is reached without too great traction.

This condition has more than once prevented our doing what is so well advised by Gerster—twisting the gut to prevent incontinence. We have feared to still further obstruct a very feeble blood supply.

It being decided that an attempt at uniting the ends of the gut is justifiable, we have the choice of three ways—the Murphy button, end-to-end suture, and suture after invagination of the upper into the anal extremity. The proper application of the button requires that a considerable portion of the anal end of the gut has been left after removal of the stricture. It is also to be remembered that there is no peritoneal covering to the ends of the gut which assists

so greatly in union within the peritoneal cavity. For this reason the ends should be well scarified where they are to come into contact when the halves of the button are pressed together, and the union should be further strengthened by a row of sutures.

In spite of all this one of our own fatal cases was due to sloughing of the upper end and extravasation of fæces into the wound.

Between end to end suture and suture after invagination the operator may choose for himself. The latter is much quicker and easier. Both will occasionally succeed and often fail, and when they fail a life will perhaps be lost which might have been saved for a time by the simpler operation of bringing the upper end of the gut out behind.

I am convinced that it is in great measure upon these points in technique as well as upon the selection of the cases that the mortality of the operation at present depends; and that the success and failures of the future will depend upon the results of careful practice and experiment along this line.

One other practical point has been forced upon the writer's attention.

In cancer of the rectum any kind of anus which may result is justifiable and desirable provided the growth can be removed. But in non-malignant stricture, as it often presents itself, especially in the old cases of so-called syphilitic stricture, the future of the operation of excision depends entirely upon the ability not only to remove the disease but to put the parts after the operation in something like the natural condition.

I do not contend for perfect fæcal control, for the patients do not have that before the operation; but they must at least be left better off after the operation than be-

fore it, and better off than they would be after colotomy to compensate for the great additional risk of one operation over the other.

It is a difficult matter to choose between the comparative discomforts of an average case of old stricture; the condition following extirpation, where the gut is brought out over the sacrum or the patient is left with two openings, both discharging fæces, one the natural one and the other somewhere else near it, generally called a fæcal fistula; and the condition following colotomy. Unless the conditions following extirpation in these cases can be made much better than those which follow colotomy, the operation will soon be crowded aside and we shall return to where we were a few years ago, with the only choice between colotomy, on the one hand, and proctotomy or dilatation on the other.

There is certainly no operation connected with the surgery of the rectum in which practice and skilful technique have so great a bearing upon the results.

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EDITED BY

FRANK P. FOSTER, M.D.

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